TOMAHAWK SCHOOL DISTRICT

Practitioner*/Parent Medication Administration Consent Form

All prescription medication dispensed at school, including students who carry and self-administer inhalers/Epi-Pens/insulin, must have written instructions signed by the practitioner and the parent/guardian. Non-prescription medications require written instructions signed by the parent/guardian only.

Name of Student:_____ D.O.B.: _____
School:_____ Grade: _____
Diagnosis(es):_____

Medication Name: _____
Dose and Route: _____
Time to be Administered at School: _____
Specific Instructions or Reasons to Contact Physician _____
_____
Date Effective: _____ to _____

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Dose and Route: _____
Time to be Administered at School: _____
Specific Instructions or Reasons to Contact Physician _____
_____
Date Effective: _____ to _____

Additional questions for practitioner for Inhalers, Epi-pens, and Insulin

Student is knowledgeable about his/her medication	○ Yes	◉ No
Student has demonstrated correct use of his/her medication	○ Yes	◉ No
Inhaler for asthma - may carry and self-administer	○ Yes	○ No
Epi-Pen for severe allergy - may carry and self-administer	○ Yes	○ No
Insulin for diabetes - may carry and self-administer	○ Yes	○ No

If students carry inhalers/Epi-Pens/insulin, it is recommended that back-up medication be stored in the health area.

Practitioner's signature directs the above medication administration and indicates his/her willingness to communicate with staff, designated by school principal or nurse, who administer the medication.

Practitioner's name, address, and phone

_____ _____
_____ Practitioner's Signature (Prescription meds only)
_____ _____
Date Signed

I hereby give permission to staff designated by school principal or nurse to give the above medication to my child according to the instructions stated above and further authorize them to contact my child's physician if necessary. I understand that whenever possible, medication will be administered at home, before or after school hours.

_____ _____
Parent/Guardian Signature Date Signed

Whenever there is any change in instructions for the above medication a new form must be completed. This includes discontinuation of the medication. A new form must be completed for each schoolyear.

***Practitioner includes physician, dentist, podiatrist, optometrist, physician assistant, and advanced practice nurse practitioner per 2001 WI Act 83.**

**Physician's Office may FAX completed form to: 715-453-5903.